STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295084	A. BUILDING _____ B. WING _____	10/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREMERIDIAN	7690 CARMEN BLVD LAS VEGAS, NV 89128

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from October 28, 2008 through October 29, 2008. The census at the beginning of the survey was 17 residents. Eight residents were sampled and 1 closed record reviewed. There were no complaints investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 150 SS=C	483.5 DEFINITION OF LTC FACILITY Definitions. For purposes of this subpart--"Facility" means, a skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of sections 1819 or 1919(a), (b), (c) and (d) of the Act. "Facility" may include a distinct part of an institution as specified in §440.40 of this chapter, but does not include an institution for the mentally retarded or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution. For Medicare, a SNF(see section 1819(a)(1)),	F 150		

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger E Dutto NHA	ADMINISTRATOR	12-18-2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 150	Continued From page 1 and for Medicaid, a NF(see section 1919(a)(1)) may not be an institution for mental diseases as defined in §435.1009. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to consistently identify itself in policy and procedures as a participant in the Medicare and Medicaid program in Nevada. Findings include: On 10/28/08 in the mid afternoon, it was noted in the Admission Packet for residents on page 31, under the heading of "II. Facility Policy Regarding Medicare/Medicaid Funded Residents" the following statements: - "CareMeridian does not participate in the Medicare and/or Medicaid Programs. If during the term of this Agreement, Medicare and/or Medicaid should become the only sources of coverage available to the Resident, the Facility's administration will assist the Resident in efforts to find a placement that accepts Medicare and/or Medicaid funded residents."	F 150	F- 150 Statement has been removed from admission package. All current residents or responsible party have been informed of the Medicare/Medicaid status of this facility	12/16/2008
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of	F 167		

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F 167	Continued From page 2 their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post notice of the availability of the most recent survey results for review by the residents. Findings include: On 10/28/08 in the midafternoon, the Administrator revealed the most recent survey results were in the "lobby book," a white, 3-ringed notebook kept in the lobby. The 3-ringed notebook did not indicate on the outside that recent survey results were contained on the inside. No statement was posted about the availability for review of the most recent survey results.	F 167	F- 167 Notice of location of survey results has been posted. Lobby book "Resident and Visitor Information Book" has been revised to read "Resident and Visitor Information Book, Current Survey and Plan of Correction inside"	12/16/2008
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to develop written policies and procedures that prohibit the mistreatment, neglect, abuse of residents and the misappropriation of resident property for residents in the state of Nevada. Findings include:	F 226		

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F 226	Continued From page 3 On 10/28/08 in the midafternoon, the Policies and Procedures for Abuse contained the following references to the state of California: - "Abuse, Suspected and Reporting of, date revised 8/02, page 2, Procedure, number 8", "...report all incidents of alleged abuse or suspected abuse to DHS within 24 hours (AB 1731)..." and under C. Corrective Action, number 3, "notification will be made to the appropriate licensing agency if the incident involves a licensed employee or to the Aide and Technician Certification Section of D.H.S", - "You are a Mandated Reporter" Legal Responsibilities, under the heading of "Reports of suspected elder or dependent adult abuse..." bullets stating "Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse investigators", - "Abuse Reporting Definitions" defines an "elder: means any person in this state, 65 years of age or older", - "Abuse, Suspected and Reporting of, date revised 8/02, page 1, under the heading of Documentation: "SOC (State of California) 341: Report of Suspected Dependent Adult/Elder Abuse",	F 226	F- 226 New policy has been written and staff trained on new policy and procedures. The Administrator and DON will review all policies for compliance once each year.	12/16/2008
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 4 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident and/or family was included in the care plan conference for 1 of 8 residents (# 4). Findings include: Resident #4 was a 41 year old male admitted on 9/25/08 with diagnoses including a history of Cardiac Arrest with resulting Encephalopathy, Laceration of Tongue and Seizures. Record review The physician 's History & Physical dated September 29, 2008 revealed that Resident #4 was responsive to verbal stimuli and followed simple commands. He was verbal intermittently. Resident #4 had failed a MBS(Modified Barium Swallow) and was receiving tube feedings through a gastrostomy tube.	F 280	F- 280 New Policy has been written to insure all residents and/or responsible party will be included in all care planning meetings. The DON and Case Manager will review all meetings and comply with all requirements under this provision RECEIVED DEC 19 2008 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	12/16/2008

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F 280	Continued From page 5 On 10/20/08 an IDT (Interdisciplinary Team) meeting included the ADON (Assistant Director of Nurses), Speech Therapist, Activities Director, Dietary and Case Manager/DON. The Plan of Care and goals were established. Interview On 10/29/08 in the morning, Resident #4's mother, who was the legal guardian, revealed that she was not included in the Care Plan meeting. She stated that, to her knowledge, there had not been any meetings since the resident was admitted. The resident's mother stated she wanted to be included in the care planning of Resident #4 and had been included in the care conferences at the previous facility. On 10/29/08 in the afternoon, the Administrator in Training (AIT) confirmed that Resident #4's mother had not participated in the care plan conferences. The AIT stated that she kept the mother informed of the resident's progress on a daily basis but had not notified the mother of the planned meetings.	F 280		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 6 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were not expired. Findings include: Observation On 10/28/08 in the afternoon, observation of the medication refrigerator located in the nurses' station revealed: - 6 vials of Lorazepem 2mg/ml (milligrams/millileter) Lot #066093 Expiration Date 6/2008	F 431	F- 431 All licensed staff have trained by contract pharmacy on proper procedures for the destruction of outdated drugs and proper documentation. DON will supervise the destruction and review the documentation with the Administrator weekly and will review documentation with the consultant pharmacist quarterly RECEIVED DEC 19 2008 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	12/16/2008

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F 431	Continued From page 7 Interview On 10/28/08 in the afternoon, the charge nurse confirmed that the medications had expired and removed the vials from the refrigerator.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish an infection control program that indicated what isolation procedure should be applied to an individual resident and failed to maintain a record of infectious incidents and corrective actions for 1 of 8 residents (#1). Findings include: Resident #1 Resident #1, was a 30 year old male who was admitted most recently on 8/8/08 with diagnoses including Cervical Spine Fracture, Cervical Fusion, Quadriplegia, Recurrent Urinary Tract	F 441		

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F 441	Continued From page 8 Infections, Recurrent Ventilator-associated Pneumonia, and a History of Recurrent Clostridium Difficile Colitis. Prior to admission, Resident #1 had been hospitalized with pneumonia and a urinary tract infection (UTI). Laboratory results from the hospitalization included the following findings: - urine culture on 7/27/08 stated "final results...predominant enterococcus faecalis...VANCOMYCIN RESISTANT ENTEROCOCCI... ." - blood cultures on 7/27/08, 7/29/08, 8/3/08 stated "no aerobic or anaerobic growth in 5 days," - sputum culture on 7/29/08 stated "light growth Acinetobacter Baumanii" and final results stated "light growth Acinetobacter Baumanii," - sputum culture on 8/3/08 stated "rare growth coagulase positive staphylococcus" and final results stated "light growth coagulase positive staphylococcus" and "METHICILLIN RESISTANT STAPHYLOCOCCUS," After admission to the facility, Resident #1 was placed on "contact isolation" by the physician and remained on contact isolation from 8/8/08 through 10/29/08. On 10/29/08 at 2:00 PM, Employee #3 reported the resident left the room for "showers" during which he was "bagged" (respirations manually assisted with an Ambu bag). Employee #3 revealed the resident could not leave room 3A (his room) due to contact isolation precautions ordered by the physician and the presence of the	F 441	F- 441 New policy has been established that all residents requiring isolation will be reevaluated every 21 days. All staff have been trained on new policy. DON and ADON will review all residents' records for compliance. DON will include the isolation review at the quarterly QA and Infection Control meeting.	12/16/2008

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F 441	Continued From page 9 resident's ventilator. On 10/29/08 at 2:10 PM, Employee #2 explained Acinetobacter in the sputum was "difficult." Resident #1 had laboratory work collected and drawn after the 8/8/08 admission including the following laboratory tests: - 8/18/08 complete blood count, - 8/11/08 complete blood count and comprehensive metabolic panel, - 9/03/08 complete blood count, renal function panel, - 9/11/08 complete blood count, - 10/6/08 complete blood count, renal function panel, and glycosylated hemoglobin (A1C), - 10/15/08 sputum culture, and - 10/17/08 urine clean catch midstream and urinanalysis. The resident's record lacked additional documented evidence of blood cultures collected after the 8/8/08 admission. A sputum culture report dated 10/19/08 identified the organism "staphylococcus aureus." A hand written note by a nurse was on the bottom of the sputum culture report that stated "telephone order received by...sputum is colonized no treatment." The record lacked additional documented evidence of a sputum culture with "Acinetobacter" or a urine culture with "predominant enterococcus faecalis" as documented in the pre-admission blood work. Review of Resident #1's record indicated a urinary tract infection was diagnosed in mid October, 2008 and initially treated with Keflex and Bactrim. The antibiotic therapy was changed to Ceftriaxone on 10/20/08 due to antibiotic	F 441		

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F 441	Continued From page 10 susceptibility of the UTI organism "Providencia stuartii." Resident #1 was interviewed (with an interpreter) on 10/29/08 at 1:30 PM in room 3A. The resident related he had been in the same room since the August admission. On 10/29/08 in the mid afternoon and upon request, Employee #3 provided the record for infectious incidents. The record was a log filled out by staff nurses when laboratory results for cultures were received. Resident #1 was kept on contact precautions from 8/8/08 through 10/29/08 in room 3A. The resident's record lacked documented evidence of infection to justify contact precautions for 82 days.	F 441		
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident who required isolation was maintained on isolation precautions to prevent the spread of infection to other residents for 1 of 8 residents (#4). Findings include: Resident #4 was a 41 year old male who was	F 442		

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F 442	Continued From page 11 admitted on 9/25/08 following Cardiac Arrest, history of ventilator dependence and now extubated. Observation On 10/28/08 in the morning, a sign posted on the doorway of Resident #4's room indicated Droplet Precautions. On 10/28/08 at 11:00 am, 2 visitors were observed inside Resident #4's room without any protective equipment including masks, gowns or glove. A female visitor was observed grooming the resident and making the bed. At 11:30 am, Resident #4 was sitting in a wheelchair in the common room outside of his room with the 2 visitors in attendance. Resident #4 did not have a protective mask on his face. The 2 visitors proceeded to take Resident #4 outside the building to the sitting area. On 10/28/08 in the afternoon, observed Resident #4 in a wheelchair being pushed in the hallway by his visitor. He was wearing a protective mask. When the visitors returned to Resident #4's room, they were observed applying a mask prior to entering the room. On 10/29/08 in the morning, 2 visitors were observed in Resident #4's room without a protective mask on. Interview On 10/28/08 at 11:30 am, the Assistant Director of Nurses (ADON) revealed that she observed visitors in Resident #4's room without protective isolation masks. The ADON stated that the	F 442	F- 442 New notification has been added to admission package to inform the residents and responsible parties of the requirements of Contact and Droplet precautions and to require that all residents use proper protective clothing when out of their room. The staff has been trained on new requirements. The Administrator and DON will monitor this requirement daily.	12/16/2008

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F 442	Continued From page 12 visitors were Resident #4's mother and father. She stated that the staff talked to the family on several occasions about wearing masks but they continued to refuse. The ADON stated she was aware that the resident did not have a mask on when he left the room. She stated she would talk to the visitors again. On 10/29/08 in the afternoon the Administrator in Training (AIT) stated that she was very familiar with Resident #4's visitors and knew the staff talked to them on numerous occasions about wearing masks due to the droplet precautions. The family refused to follow their direction. Record Review Physician's order dated 9/26/08, indicated "Respiratory Isolation/Droplet Precautions R/T (related to) Acinobacter in Sputum." Review of Policy Titled - Droplet Precautions - Dated January 2007 revealed: "Droplet Precautions shall be used in addition to Standard Precautions for residents with infections that can be transmitted by droplets... MASKS 1. A mask should be worn when within 3 feet of the resident TRANSPORT 1. Limit the movement and transport of the resident. If transport is necessary, masking the resident may minimize dispersal of droplets."	F 442		

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F 442	Continued From page 13 Review of Policy titled - Standard Precautions - dated January 2007 revealed: "1. Gloves should be worn whenever exposure to the following is anticipated: - Saliva - Mucous Membranes 3. Gowns/Aprons should be worn when there is potential for soiling clothes with blood/body fluids. 10. Linen - soiled linen should be handled as little as possible. Gloves should be worn to handle linen with blood or body fluids."	F 442	F- 499	
F 499 SS=C	483.75(g) STAFF QUALIFICATIONS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to employ a Director of Nursing (DON) with a current registered nurse license for 12 days after the license expired. Findings include: On 10/28/08 in the midafternoon, the Director of Nursing's (DON) personnel file lacked evidence of a current registered nursing (RN) license. After being questioned about the possession of a current RN license, the DON left the building. The assistant DON reported the DON went to an office of the State Board of Nursing. The	F 499	New policy requiring the quarterly review of all employee records and verification of licenses will be conducted by HR staff monthly and will be reviewed by DON and /or Administrator quarterly.	12/16/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295084	A. BUILDING _____ B. WING _____	10/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREMERIDIAN	7690 CARMEN BLVD LAS VEGAS, NV 89128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 499	Continued From page 14 Administrator stated the DON was an administrator-in-training as well as the Director of Nursing. On 10/29/08 at 7:00 AM, the Administrator provided license verification of the DON's registered nurse status. During the exit conference, the Administrator stated he was unaware that the DON's nursing license had expired.	F 499		